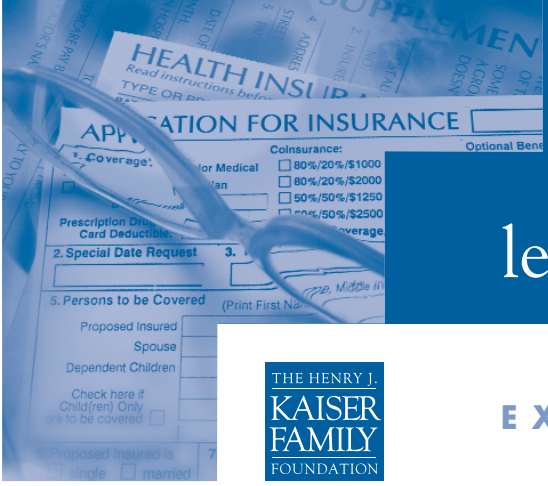


How accessible is Individual Health Insurance *for* consumers *in* less-than-perfect health?

THE HENRY J. KAISER FAMILY FOUNDATION

EXECUTIVE SUMMARY - JUNE 2001

BACKGROUND

Most Americans obtain health insurance through an employer, but people who don't have access to such coverage and are ineligible for public programs like Medicaid and Medicare must rely on individually-purchased health insurance. Yet, the individual insurance market can be a difficult place to buy coverage, especially for people who are in less-than-perfect health. Access to and the cost of coverage is very much dependent on a person's health status, age, place of residence, and other factors. Understanding how this market works for people in different circumstances is important for several reasons. First, some 16 million Americans bought health insurance in the individual market in 1999. Second, anyone can find himself or herself in need of individual market coverage at some point in their lives. Common circumstances leading people to seek such coverage include self-employment, early retirement, working part time, divorce or widowhood, or "aging off" a parent's policy. Finally, federal policymakers are debating proposals to expand coverage for the uninsured by subsidizing their purchase of health insurance in the individual market through tax credits, so it is important to understand what this market can and cannot offer those who lack health insurance today.

METHODOLOGY

The Kaiser Family Foundation commissioned researchers at Georgetown University's Institute for Health Care Research and Policy to design a study testing access to coverage in the individual health insurance market by constructing seven hypothetical applicants and asking insurers to consider them as though they were real consumers. For each consumer, we asked 19 insurance companies and HMOs in eight markets around the country (Arlington Heights, Illinois; Austin, Texas; Corning, Iowa; Fresno, California; Miami, Florida; Richmond, Virginia; Tucson, Arizona; and Winamac, Indiana) how they would respond to an application for coverage. Communities were chosen based on geographic diversity and to test how the individual market functions in states with few restrictions on insurer practices. This resulted in a total of 60 applications per person and a total of 420 applications for the group. Each insurer was asked to "underwrite" the applicants (that is, to determine whether or not they would be offered coverage and on what terms) using a policy that included a $500 deductible and a $20 co-payment per physician office visit.

RESULTS FOR EACH OF THE APPLICANTS

Insurers responded to these hypothetical applications by either accepting the applicant for standard coverage at a standard rate for a healthy person (i.e., a "clean offer"), rejecting the applicant, offering coverage with special restrictions on covered benefits (e.g., to exclude benefits through a "rider"), or offering coverage at a higher-than-standard premium (i.e., a "rate-up" or surcharge). Some responses combined special benefit restrictions with a rate-up. The results for each of the consumers were as follows:

***ALICE*, a 24-year-old waitress with hay fever.** Alice had her application rejected 5 times, or 8% of the time. She received 3 clean offers of coverage. The vast majority of offers (46 of 55) she received had limitations on benefits based on her health condition. Alice was offered policies with exclusion riders that would eliminate coverage for her hay fever or, in three cases, for her entire upper respiratory system. Other offers modified coverage under the policy by increasing the annual deductible from $500 to $2,500, or increasing the cost sharing (e.g., deductibles or coinsurance) for prescription drugs. Ten offers applied a premium surcharge, or rate-up, ranging from 20-40% (including four that restricted benefits as well). The average annual premium quoted to Alice was $1,656, although the prices on her offers ranged from $408 to $4,596 per year.

***BOB*, a 36-year-old consultant who injured his knee in college and had it surgically repaired 10 years ago.** Bob was turned down 7 times, or 12% of the time. He received 15 clean offers of coverage and was one of only two of the applicants who received at least one clean offer in each market where he applied. In 34 instances, carriers sought to

limit Bob's coverage in some way. Most often, Bob was offered a policy that excluded coverage for his knee. He also had five offers with premium surcharges ranging from 25% to 40% (including one with benefit restrictions as well). The average annual premium quoted to Bob was $1,764, although the prices on his offers ranged from $588 to $5,112 per year.

***THE CRANE FAMILY* (Cathy and Carl, both aged 36, daughter Cindy, 10, and son Colin, 12, who has asthma and recurring ear infections).** The Crane family was offered coverage 60 times, but in nine cases the offer excluded Colin from the policy. The entire Crane family received 3 clean offers of coverage. The vast majority of offers to cover the entire family came with limitations. Some attached riders excluding coverage for Colin's asthma, other respiratory disorders, his ears, or even his entire respiratory system. The Cranes were also offered policies that imposed higher cost sharing on prescription drugs and other services, or that increased the annual deductible to $2,500. Seventeen offers imposed premium rate-ups ranging from 20% to 50% (including 12 that also imposed benefit restrictions). The average annual premium quoted the Cranes was $5,460, although the prices on their offers ranged from $1,692 to $15,444 per year.

***DENISE*, a 48-year-old actress and seven-year breast cancer survivor.** Denise was rejected 26 times, or 43% of the time, and received 11 clean offers of coverage. However, she was also the only other applicant to receive one clean offer in each market where she applied. Of the 34 offers of coverage Denise received, 18 had limits on benefits covered. Most often the policies had riders excluding coverage for her treated breast, her implant, or cancer of any type. Eighteen offers imposed a premium surcharge, ranging from 40% to 100% (including 13 that were accompanied by some other benefit restriction). The average annual premium for Denise was $3,912. The cost of coverage on her offers ranged from $1,464 to $16,344 per year.

***EMILY*, a 56-year-old widow who is "situationally depressed."** Emily was rejected 14 times, or 23% of the time, while receiving 9 clean offers. Of the 46 offers she received, 23 limited benefits in some fashion, such as excluding coverage for depression or for any mental/nervous disorder and increasing cost sharing for prescription drugs. Thirty of Emily's offers imposed a premium surcharge, ranging from 20% to 50% (including 16 that also imposed some other special coverage limit or restriction). The average annual premium for Emily was $4,056. Her offers ranged in price from $1,920 to $10,992 per year.

***FRANK*, a 62-year-old retired salesman who smokes, is overweight, and has high blood pressure.** Frank was rejected 33 times (55%) and received 2 clean offers. Of his 27 offers of coverage, three included riders excluding coverage of his circulatory system. A total of 25 offers imposed a premium surcharge, ranging from 16% to 110% (including three that also limited benefits). The average annual premium offered to Frank was $9,936, with a range from $2,928 to $30,048.

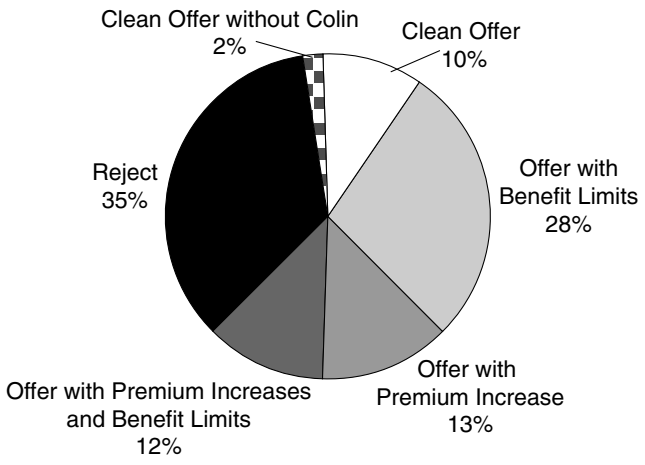
***GREG*, a 36-year-old writer who is HIV-positive.** Insurers in the individual market generally consider HIV to be an "uninsurable" condition. As a result, Greg was rejected for coverage all 60 times.

RESULTS ACROSS ALL OF THE APPLICANTS

Taken as a group, the 7 hypothetical insurance consumers made 420 applications for coverage. Most of the time (90%), the consumers were unable to obtain the coverage for which they applied at a standard rate – only 43 clean offers of coverage were made (10%). They were rejected 154 times (including 9 cases where Colin was rejected but the remainder of his family was accepted), or 37% of the time. Greg accounted for 60 of the rejections. Among the 63% of applications that were accepted, the vast majority (53%) imposed benefit restrictions (118, representing 28% of all applications), premium surcharges (56, or 13%), or both (49, or 12%).

The average premium quoted for the five applicants who received any offers of coverage was $333 per month, or $3,996 per year. Had these applicants been in perfect health (and therefore not denied coverage or rated-up), the average standard rate that would have been available to them would have been $249 per month, or $2,988 per year. The average premium rate-up, when applied on a single-only policy, was 38%.

Response to All Individuals in All Eight Markets



Results varied somewhat across states, with differences in state insurance rules helping to explain some of that variation. For example, California and Indiana prohibit exclusion riders that limit benefits while other states we studied do not. Carriers in Fresno and Winamac had lower offer rates and imposed premium surcharges more frequently than insurers in other markets. On average, our applicants were offered coverage only about half of the time in Fresno and Winamac, compared to about two-thirds of the time in the other communities we studied. In addition, when offered coverage in Fresno and Winamac, our applicants had premium surcharges applied 58% and 82% of the time respectively, compared to only 25-39% of the time in the other markets studied.

IMPLICATIONS OF THE STUDY FOR CONSUMERS AND POLICYMAKERS

Implications for Consumers: Consumers who are in less-than-perfect health clearly face barriers to obtaining health insurance coverage in the individual insurance market. Insurance carriers often decline to cover people who have pre-existing medical conditions, and even when they offer coverage, frequently impose severe limitations on the coverage for any expenses related to the pre-existing condition or charge more to cover these expenses. This can price insurance out of the reach of many consumers in poor health or create significant gaps in coverage that could result in being underinsured.

The pattern of carrier responses to this group of hypothetical applicants might not be repeated for a different group with different health characteristics. For example, the fact that Greg had HIV made it almost certain he would be rejected by most or all carriers (some states require certain carriers in the individual market to offer coverage to all applicants). Similarly, Frank's multiple health risks (smoking, weight, high blood pressure) made it likely that he would be rejected quite often. But it is important to recognize, too, that many Americans would fit similar profiles. Like Colin Crane, nearly 17 million Americans suffer from asthma. Like Denise, 8.4 million Americans are cancer survivors. And like Greg, some 800,000 to 900,000 Americans are living with HIV, while millions of other Americans have arthritis, diabetes, or other conditions insurers often consider "uninsurable." Anyone with a health condition could face some difficulty obtaining coverage in the individual market.

At the same time, the actions of many carriers make it clear that medical underwriting is practiced very differently by different health insurers. Emily, for example, was rejected as often as she was offered coverage with a premium rate-up. Denise received one of the largest number of rejections, but also received one of the largest number of clean offers. Two plans that rejected Alice offered coverage to Frank. In fact, rarely were one carrier's underwriting actions duplicated by any other carrier.

Consumers who are in perfect health can also face financial barriers to coverage in the individual market. Insurance carriers generally price coverage based on the age, sex, and geographic location of the applicant. Of the policies examined in this study, the "standard rates" – that is, the advertised premiums available to healthy consumers – for a 62-year old man were three to six times those available to a 24-year-old woman. Geographic price differences can also sometimes be dramatic. In this study, for example, carriers offering coverage in Miami charged premiums that were an average of twice those charged in Arlington Heights, Illinois, a suburb of Chicago. Premiums in Corning, Iowa, and Winamac, Indiana, – two small, rural communities – tended to be much lower than in other areas studied.

Healthy consumers may also find it difficult to purchase comprehensive coverage in the individual market. In particular, coverage for maternity benefits, mental health care, and prescription medications tends to be limited, especially in comparison to what is typically offered under group health plans.

Finally, the process of applying for individual coverage can be involved and expensive. Applying for individual health insurance can take anywhere from two to eight weeks, and consumers typically are asked to provide a personal check covering the first month's premium with their applications, making "shopping around" for coverage an expensive prospect. Consumers don't know whether coverage will be issued, or under what terms or at what cost, until the underwriting process is complete. Underwriting begins with the application itself, which asks consumers a series of questions about their current health status and health history. In some cases, insurers may ask for additional information, including copies of medical records or other information from the applicant's physician, a sample of the applicant's blood, urine or saliva, and/or a physical examination of the applicant by a paramedic. Some insurers also consult a database maintained by the insurance industry for information about adverse underwriting actions that may have been taken by other carriers.

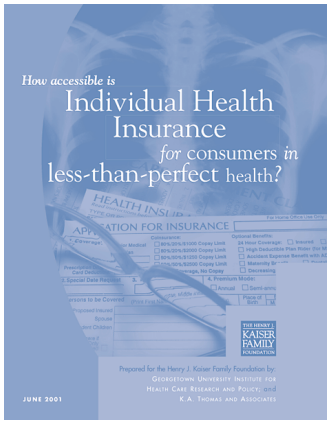
Implications for Policymakers: Regulation of individual health insurance coverage is largely under the jurisdiction of states, and most have taken some action in response to these access problems. Many states have enacted high risk pools to make coverage available to residents when carriers turn them down or offer substandard coverage. These programs offer an important health insurance option to people who are otherwise unable to obtain private coverage. However, state high risk pool coverage is always more expensive than comparable private insurance policies. In addition, many states restrict covered benefits or cap enrollment in order to hold down pool costs. As a result,

only about 100,000 individuals are enrolled in state high risk pools nationwide, raising questions about whether state high risk pools, as currently structured, are equipped to offer a meaningful coverage option to all those who may encounter barriers in the private individual market based on the results of this study.

A handful of states have rules prohibiting carriers from placing exclusionary riders (which eliminate coverage for pre-existing conditions) on policies. These states do not, however, limit other actions medical underwriters may take against applicants. The results of the study suggest that this produces an unintended consequence: carriers in these states decline more applicants and apply premium rate-ups more frequently on those applicants they do accept. California and Indiana, states that limit the use of exclusion riders, had lower offer rates and higher premium surcharge rates than study states that have no such prohibitions.

A few states have enacted laws intended to make coverage in the individual health insurance market more evenly available to consumers. New York, for example, requires all individual market health insurance to be sold on a guaranteed issue, community rated basis – which means no resident can be turned down or charged more due to their health status, age, or gender. New York also requires insurers to sell standardized policies that cover maternity benefits, prescription drugs, and mental health care. Had our hypothetical consumers applied for health insurance in Albany, New York, they all would have been sold a standard policy at a standard rate without any exclusion riders or other coverage penalties for their health conditions. There is, however, a cost to such regulation. The average premium for our single applicants in Albany was $4,104 per year. While that was only slightly higher than the average premium ($3,996 a year) quoted to many of our applicants in less regulated markets, it is significantly higher than the standard rates ($2,988 a year) charged to healthy applicants in those markets. In other words, young and healthy consumers would face greater financial barriers to coverage in New York and other tightly regulated states than they would in our test markets.

Inability to afford coverage is the primary reason why 43 million Americans are uninsured, and some federal policymakers have proposed addressing this affordability problem by offering tax credits to help people buy coverage in the individual insurance market. This study has implications for how well such tax credits would work. Even consumers with relatively mild health conditions face barriers in the individual insurance market as it's currently structured, including denials of coverage, limitations on benefits, and premium surcharges. A tax credit of $1,000 for individuals (and $2,000 for families) – a commonly proposed amount – would cover only 25% of the average annual premium quoted to the hypothetical single consumers in this study for a benefit package that includes a $500 annual deductible. Even if these single consumers were in perfect health, they would face an average premium of $2,988 per year in the markets we studied, three times the value of a $1,000 tax credit. Most low income and many moderate income consumers would not be able to afford these premiums. Finally, the wide variation of premiums in this market suggests that while a flat tax credit of $1,000 would cover a substantial portion of the premium in some cases – e.g., for Alice, a 24-year-old with a relatively mild health condition – it may not be sufficient for many consumers whose age, place of residence, or health status makes health insurance especially expensive. ■



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This summary (#3136) and the full report (#3133) are available on the Kaiser Family Foundation's web site at www.kff.org or by calling the Foundation's Publication Request Line at 1-800-656-4533.

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